

BÖLÜM 29

LOKAL BÖLGESEL REKÜRRENSENDE TEDAVİ SEÇENEKLERİ- REİRRADİASYON

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GİRİŞ

Meme kanseri standart küratif tedavisi, adjuvan radyoterapi (RT) ile birlikte meme koruyucu cerrahi (MKC) veya mastektomi, ya da tek başına mastektomidir. Genel sağkalım sonuçları, güncel sistemik ve lokal tedavi seçenekleri ile oldukça iyi olmakla birlikte az sayıda hastada ipsilateral lokorejyonel rekkürrensler görülebilmektedir (1-3). İlk tedavide RT uygulanmış olan lokal nüks hastalarının tedavisi ileri cerrahi, sistemik tedavi ve reirradiasyonu kapsayan karmaşık bir yaklaşım gerektirir. İzole lokal rekkürrenslerde reirradiasyon definitif veya adjuvan yaklaşımla yapılabilirken, kanama ve ağrı için palyatif olarak uygulanabilir. Lokal rekkürrenslerde en iyi sonuçlar gros total rezeksiyon sonrası sistemik tedavi ve reirradiasyondan oluşan kombine tedaviler ile bildirilmiştir (4). Buna rağmen reirradiasyon için hasta seçimi potansiyel toksisiteler sebebiyle dikkatle yapılmalıdır. Günümüze kadar hem intakt meme hem de göğüs duvarı reirradiasyonu; interstisyel brakiterapi, foton-elektron kombinasyonları, 3 boyutlu konformal RT, yoğunluk ayarlı RT, volümetrik ayarlı ark RT, RT ile eş zamanlı hipertermi ve proton RT gibi birçok teknik ile uygulanmıştır ve bu teknikler halen gelişmeye ve araştırmaya açık bir konudur.

Meme Koruyucu Cerrahi Sonrası Reirradiasyon

Meme kanseri tanısı aldıktan sonra, primer olarak MKC ve ardından tüm meme radyoterapisi (TMR) ile tedavi edilmiş hastaların lokal nüks oranları 5 yıllık %2-

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proton ile yapılan rerradiasyonlarda LN bölgeleri de reirradiasyon alanına dahil edilebilmektedir (61,63). Mayo Klinik'in 72 hastalık meme kanseri reirradiasyon sonuçlarını yayınladığı çalışmasında, 20 hastaya proton RT ile reirradiasyon yapılmış, 19 hastaya yalnızca nodal bölge re-RT uygulanmıştır. Bu çalışmada kalp, koroner arterler ve ipsilateral akciğer için foton ve proton tedavilerinde normal doku dozları karşılaştırılmış ve proton ile daha düşük dozlar elde edildiği gösterilmesine rağmen toksisite farkı bulunmamıştır. Grad 3 toksisite %13 hastada (%10 akut cilt toksisitesi ve %3 geç cilt nekrozu) görülmüştür. İlk RT ile reirradiasyon arası sürenin kısa olması ve alanların çakışması artmış toksisite ile ilişkili bulunmuştur (63).

SONUÇ

Meme kanseri lokal rekürrenslerinde reirradiasyon farklı RT teknikleri ile, kabul edilebilir toksisite, umut verici lokal kontrol ve sağkalım sonuçları ile uygulanabilir görülmektedir. Hasta seçimi multidisipliner yaklaşımla ve hasta tercihi göz önüne alınarak yapılmalıdır. Özellikle brakiterapi, IORT ve hipertermi teknikleri için deneyimli ve donanımlı merkezlere ihtiyaç vardır. Çoğu merkez için uygulanabilir olan yoğunluk ayarlı veya volümerik ayarlı ark RT tekniklerini kullanırken ise oluşabilecek grad 3 ve üzeri toksisiteyi yönetim planını önceden yapmak faydalı olacaktır.

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